Referring GP:

Psyc Referral to:

Dr Stephen Wolfson
Provider No. 5340201J
307/39 East Esplanade,
Manly NSW 2095 Australia
steve@neurocogsystem.com
Phone 02 82249670
Fax 02 8224 9674

____
Date

Dear Dr. Stephen Wolfson,

Please see______________________________*(Full Name of patient)* for psychological assessment and therapy under a Mental Health Care Plan (MHCP).
I approve 6 initial sessions with a Psychologist/Clinical Psychologist under Better Access.
Please see patient's information and MHCP below.

I look forward to receiving your written progress report regarding this patient upon completion of the 6 sessions for approval of additional sessions if needed.

Yours sincerely,

Referring GP signature

Adult Referral/Mental Health Treatment Plan

MBS item number | **Referral Date**

PATIENT INFORMATION

Name
Date of Birth
Gender
Medicare/Ref Number
Healthcare Card/ Pension No.
Contact Email
Mobile Phone Number
Home Address
Other care plan
AHP or nurse currently involved in patient care
Medical Records No.
Children age 0-18?

EMERGENCY CONTACT

Name
Relationship
Phone Number
Email

PATIENT MENTAL HEALTH ASSESSMENT

(select from drop downs and use fill in's as needed)

Presenting Problem

Specific Features
Anecdotes/Examples

Reality Testing
Functioning
Impact Event
Overall Status
Internal/External Stressors

RISKS

Self Harm/Suicidal
Intent
Plan
Means
Harm to Others/Homicidal
Intent
Plan

Means

Safety Plan

EVALUATION

Presentation

Appearance

Grooming/Self-Care

Dress/Caretaking

Posture/Stance

State

Condition/Health

Mannerism/Behaviour

Physical Functioning/Ability

Arousal/Energy Level

Attentiveness/Interest

Emotional/Affective State

Mood/Tone

Awareness/
Consciousness Level

Speech

Thinking

Ideation

Intellect

Symptoms

Mood

Psychosis

Anxiety

Obsessions/Compulsions

Trauma

Disassociation

Somatic

Eating

Sleep

Substances

Personality

Strengths/Limitation

BACKGROUND INFORMATION

(select from drop downs and use fill in's as needed)

Overview	
Medication	
Allergies	
Substance Use	
Co-existing Conditions	
Living arrangements	
Social relationship	
Relationship	
Occupation	
Interests	
Habits	
Family and other supports	
Engagement and motivation	
Mental health history	
Salient social history	
Salient medical/biological history	
Salient developmental issues	
Family Psychiatric history	

DIAGNOSIS

Provisional diagnosis DSM/ICD 10/11 of mental health disorder

General Diagnosis

Outcome Tool Used

Tool	Date	Score

Copy of completed tool provided to referred practitioner

Case formulation (factors: predisposing, precipitating, perpetuating, protective)

PATIENT PLAN

(select from drop downs and use fill in's as needed)

Clients Needs/Issues

Goals

Interventions/ Relapse Prevention

Referrals

Crisis/Relapse

Psychoeducation provided?

Plan added to the patient's records?

Copy of the plan offered to other provider/patient?

COMPLETEING PLAN

Discussed the assessment with the patient?

Discussed all aspects of the plan and the agreed date for review?

Offered a copy of the plan to the patient and/or their carer (if agreed by patient)?

Date Plan completed

REVIEW

MBS item number

Date

Outcome Tool Used

Tool	Date	Score

COMMENTS

Progress on goals and actions

Checking, reinforcing and expanding education

Communication

Modification of treatment plan (if required)

Intervention/relapse prevention plan (if required)

RECORD OF PATIENT CONSENT

I, ____*(name of patient),* agree to information about my health being recorded in my medial file and shared between health care providers included in this form involved in management of my healthcare. I understand I must inform my GP if I wish to change any provider listed in this form. I understand as part of my care under this Treatment Plan, I should attend my GP for review at least 4 weeks after but within 6 months after this plan was created. I consent to the release of the following information to care support and emergency contacts:

Name	**Assessment**			**Treatment Plan**		
	Yes		**No**	**Yes**		**No**
		With the following limitation:			With the following limitation:	
		With the following limitation:			With the following limitation:	
		With the following limitation:			With the following limitation:	

Signature of patient

Date

I, ____ have discussed the plan and referral(s) with the patient.
Full name of GP

Signature of GP

Date